

# Dental Billing: Using the ADA 2012 Claim Form

Indiana Health Coverage Programs  
Gainwell Technologies  
ADA Web Training



# Session Objectives



- Preview the new *ADA 2012 Dental Claim Form* requirements and changes
- Explain the new fields on the Provider Healthcare Portal related to the update
- Review the 837D format requirements
- Helpful tools
- Q&A

# ADA 2012 Claim Form

- The new form will be effective based on date received; effective date to be announced
- For more information, see [BR201818](#)
- Watch upcoming publications from the IHCP for more information
- Changes to be published in the *Dental Services* provider reference module at next update
- While some fields are “optional” the information entered in the fields will be validated to ensure the data entered is appropriate



# Fields 1, 20, and 23 – Header Information, Patient Information

## ADA American Dental Association® Dental Claim Form

### HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- Statement of Actual Services       Request for Predetermination/Preauthorization  
 EPSDT / Title XIX

2. Predetermination/Preauthorization Number

### INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

### OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental?       Medical?       (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)      7. Gender  M  F      8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number      10. Patient's Relationship to Person named in #5  
 Self     Spouse     Dependent     Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

### POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

IHCP member last name, first name

13. Date of Birth (MM/DD/CCYY)      14. Gender  M  F      15. Policyholder/Subscriber ID (SSN or ID#)  
 Member Medicaid number

16. Plan/Group Number      17. Employer Name

### PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above  
 Self     Spouse     Dependent Child     Other      19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

IHCP member last name, first name

21. Date of Birth (MM/DD/CCYY)      22. Gender  M  F      23. Patient ID/Account # (Assigned by Dentist)  
 Office internal patient number

# Fields 24 – 31 Service Details

RECORD OF SERVICES PROVIDED										
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2	✓	✓	✓	✓	✓	✓	✓	✓		✓
3										
4										
5										
6										
7										
8										
9										
10										

Field 25 - Area of Oral Cavity Quadrant can be listed when applicable

✓ = Required field for ALL claims

✓ = Required field, if applicable

If Field 29a (Diagnosis Pointer) is entered, Field 34 Diagnosis Code Qualifier and 34a Diagnosis Code MUST be completed. (See Slide 8.)



# Field 25 – Oral Cavity Codes Accepted

Code	Description
L	Left
R	Right
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant

These codes will be required for some procedure codes. Please monitor future bulletins and banners for more information.



# Field 31A – Other Fees

RECORD OF SERVICES PROVIDED																				
24. Procedure Date (MM/DD/CCYY)		25. Area of Oral Cavity		26. Tooth System		27. Tooth Number(s) or Letter(s)		28. Tooth Surface		29. Procedure Code		29a. Diag. Pointer		29b. Qty.		30. Description		31. Fee		
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
33. Missing Teeth Information (Place an "X" on each missing tooth.)										34. Diagnosis Code List Qualifier				(ICD-9 = B; ICD-10 = AB)		31a. Other Fee(s)				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s)		A	C	32. Total Fee
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A")		B	D	
35. Remarks																				

31a. Other Fee(s)	

**No information should be entered in this field**



# Fields 34 and 34a – Diagnosis Qualifier and Diagnosis Code

34. Diagnosis Code List Qualifier	<input type="text"/>	<input type="text"/>	( ICD-9 = B; ICD-10 = AB )
34a. Diagnosis Code(s) (Primary diagnosis in "A")	A	<input type="text"/>	C <input type="text"/>
	B	<input type="text"/>	D <input type="text"/>

- New fields for ADA 2012
- Fields 34 and 34a are optional
  - Required if Field 29a (Diagnosis Pointer) is completed
- Field 34 – When applicable, enter the diagnosis qualifier of AB
  - Qualifier AB indicates an ICD-10 diagnosis will be entered in Field 34a
- Field 34a – If a diagnosis qualifier is indicated, a diagnosis code MUST be entered



# Field 35 – Remarks Field

- As in the past, this field is required to report primary insurance payment
- **Enter ONLY the amount paid**
  - Paid amount can be handwritten in **Black** ink

35. Remarks



# Fields 38-47 – Ancillary Claim/Treatment Information

ANCILLARY CLAIM/TREATMENT INFORMATION		
38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) <input type="checkbox"/>	
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY) <input type="text"/>	
42. Months of Treatment <input type="text"/>	43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY) <input type="text"/>
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident		
46. Date of Accident (MM/DD/CCYY) <input type="text"/>		47. Auto Accident State <input type="text"/>

- Field 38 is a **NEW** required field
- Fields 39 – 47 are required, if applicable
- Field 47 is a required field only if Field 45 indicates an auto accident



# Fields 48, 49 and 52a – Group or Billing Location

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Enter the service location as listed on the  
provider enrollment profile

49. NPI **Group or  
billing provider NPI**

50. License Number

51. SSN or TIN

52. Phone  
Number

52a. Additional  
Provider ID

Taxonomy related to group  
or billing provider location



# Field 54 – Rendering Provider

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

<input type="checkbox"/>		<input type="checkbox"/>	
<input checked="" type="checkbox"/>		<input type="checkbox"/>	
Signed (Treating Dentist)		Date	
54. NPI	Rendering provider NPI	55. License Number	
56. Address, City, State, Zip Code		56a. Provider Specialty Code	
57. Phone Number		58. Additional Provider ID	

- Field 54 – Enter the NPI of the provider rendering the services
  - This NPI will be the same as the NPI of the billing provider in field 49, unless the billing entity is a group.
  - If the billing entity is a group, the rendering provider must be linked to the group's enrollment.



# New Fields – Provider Healthcare Portal



# Diagnosis Codes (optional)

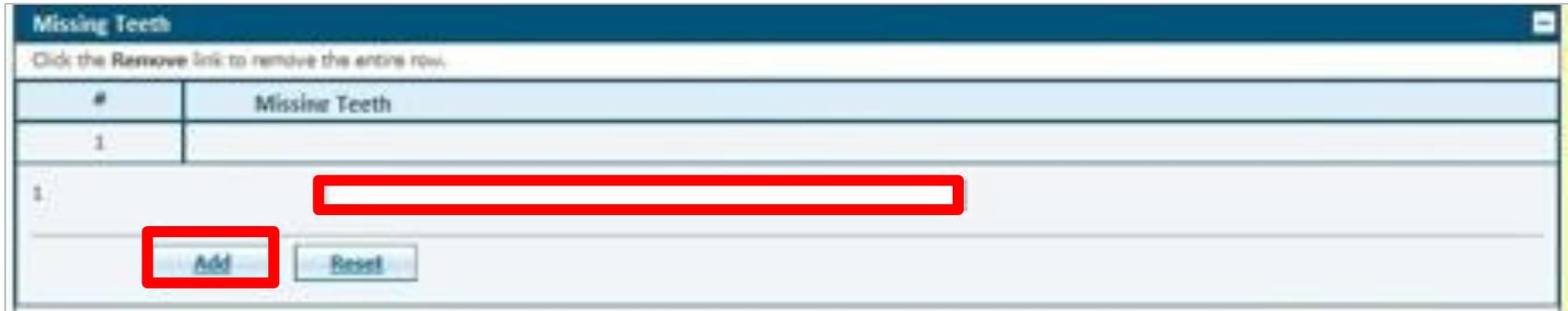
Diagnosis Codes

Select the row number to edit the row. Click the Remove link to remove the entire row.  
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code
1	Diagnosis Type: ICD-10-CM	Diagnosis Code: <input type="text"/>

If reporting diagnosis codes, type the code in the Diagnosis Code box and click **“Add”**

# Missing Teeth (optional)



The screenshot shows a web form titled "Missing Teeth". At the top, there is a blue header bar with the title. Below the header, there is a light blue instruction bar that says "Click the Remove link to remove the entire row." Below this is a table with two columns: "#" and "Missing Teeth". The table has one row with the number "1" in the first column and an empty text box in the second column. Below the table, there are two buttons: "Add" and "Reset". The "Add" button is highlighted with a red box, and the text box in the table is also highlighted with a red box.

#	Missing Teeth
1	

If reporting missing teeth, type the tooth number in the box and click **“Add”**

# Service Details – New Fields

Service Details

Select the row number to add the row. Click the Remove link to remove the entire row.

#	Service Date	Tooth Number	Procedure Code	Charge Amount	Units	Action
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Click to collapse.

\*Service Date#

Diagnosis Pointers

Oral Cavity Area

Tooth Surface

\*Procedure Code#

Charge Amount  \*Units  Line Item Control#

Other Fees

Rendering Provider ID   ID Type   Rendering Taxonomy

- **New** fields
- Diagnosis pointers – Required if diagnosis codes are entered in header (use of diagnosis codes is optional)
- Oral cavity area – Not required
- Other fees – **NO** information should be entered in this field



# 837D Transactions



# 837D Requirements

- Contact your system vendor about changes related to the new form that may be required for billing to the IHCP
  - The *Companion Guide* will be available on the [IHCP Companion Guides](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers)
  - Contact the EDI Unit at Gainwell Technologies for additional information
  - 1-800-457-4584

The screenshot shows the Indiana Medicaid for Providers website. The header includes the logo and navigation links: "About Indiana Medicaid", "Become a Provider", "General Provider Services", "Provider-Specific Information", "News, Bulletins, and Banners", and "QUICK LINKS". The main content area is titled "IHCP COMPANION GUIDES" and contains the following text:

[Provider Home](#) / [General Provider Services](#) / [Electronic Data Interchange \(EDI\) Solutions](#) / [IHCP Companion Guides](#)

## IHCP COMPANION GUIDES

This page contains *IHCP Companion Guides* for production version [5010](#).

### HIPAA 5010 COMPANION GUIDES

This list features *Health Insurance Portability and Accountability Act* (HIPAA) version 5010 *IHCP Companion Guides* to be used for version 5010 transactions. The guides contain structure and transaction specifications. The *IHCP Companion Guide Overview* and the *IHCP Notes* provide Indiana Medicaid-specific information. These guides have been updated to include information and modifications for CoreMMIS. See the revision history document for specific updates. Providers and electronic data interchange (EDI) vendors developing software for electronic data interchange may need to view multiple guides. The [IHCP Upcoming Companion Guide Changes](#) are available on a separate page.

Name	Date Updated
<a href="#">IHCP Communications Guide V3.2</a>	April 2017

The right sidebar contains a "QUICK LINKS" menu with the following items: Contact Us, Verify Member Eligibility, Check Claims Status, Access Provider Profile, Code Sets/Tables, Electronic Data Interchange, Professional Fee Schedule, Outpatient Fee Schedule, Forms, Provider Reference Materials, Pharmacy Services, Prior Authorization, Provider Enrollment, IHCP Provider Locator, and OPR Search Tool.

# Helpful Tools

- IHCP website at [in.gov/medicaid/providers](http://in.gov/medicaid/providers)
  - [Provider Reference Materials](#)
- Customer Assistance available 8 a.m.– 6 p.m. EST Monday – Friday
  - 1-800-457-4584
- IHCP Provider Relations Field Consultants
  - See the [Provider Relations Field Consultants](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers)
- Secure correspondence via the Provider Healthcare Portal
- Written Correspondence
  - Gainwell – Written Correspondence  
P.O. Box 7263  
Indianapolis, In 46207-7263



# Questions

